

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005054	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 08/08/2013
NAME OF PROVIDER OR SUPPLIER RIVERVIEW HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 395 WESTFIELD RD NOBLESVILLE, IN 46060		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for one State hospital complaint investigation.</p> <p>Complaint Number: IN00131137 Substantiated: no deficiencies cited</p> <p>Facility Number: 005054</p> <p>Date: 8/8/13</p> <p>Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor</p> <p>Riverview Hospital is in compliance with 410 IAC 15-1.6.2, Emergency services, Indiana Hospital Licensure Rules.</p> <p>QA: cloughlin 08/15/13</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE